The Regulation and Quality Improvement Authority

# Inspection Report

**Name of Service:** Abbeylands Care Home - Seapark Unit

**Provider:** Beaumont Care Homes Limited

**Date of Inspection:** 10 June 2025

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

## 1.0 Service information

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| **Organisation/Registered Provider:** | Beaumont Care Homes Limited |
| **Responsible Individual:** | Mrs Ruth Burrows |
| **Registered Manager:** | Mr Leslie Stephens |
| **Service Profile:**<br>Abbeylands Care Home - Seapark Unit is a registered residential care home which provides health and social care for up to 37 residents. The home is divided over two floors, with communal lounges, bathrooms and dining rooms on each floor.<br><br>There is also a registered nursing home located within the same building. The registered manager is responsible for both services. | |

## 2.0 Inspection summary

An unannounced inspection took place on 10 June 2025, from 10.00am to 3.00pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The inspection also reviewed one area for improvement identified at the last care inspection, the remaining areas for improvement were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. However, improvements were necessary in relation to personal medication records and the management of medicines at admission.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, residents were being administered their medicines as prescribed.

The area for improvement in relation to safe storage of medicines identified at the last care inspection was assessed as met. Details of the inspection findings, including areas for improvement carried forward for review at the next inspection and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

Residents were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the residents well.

RQIA would like to thank the staff for their assistance throughout the inspection.

## 3.0 The inspection

## 3.1 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection, information held by RQIA about this home was reviewed. This included areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from residents, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

## 3.2 What people told us about the service and their quality of life

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after residents and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each resident liked to take their medicines and medicines were administered in accordance with individual resident preference. Staff also said that they prioritised residents who required pain relief and time-critical medicines during each medicine round.

No completed questionnaires or responses to the staff survey were received following the inspection.

## 3.3 Inspection findings

### 3.3.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in residential care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

Some personal medication records were not up to date with the most recent prescription and some were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. In addition, some records did not have a second verification signature and the date of writing had not been recorded. An area for improvement was identified.

Copies of residents' prescriptions were retained so that any entry on the personal medication record could be checked against the prescription. However, a copy of the discharge letter for one resident was not available (see section 3.3.4).

All residents should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

Residents will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the resident's distress and if the prescribed medicine is effective for the resident.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were clearly recorded on the personal medication record. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain and other factors. Records of administration included the reason for and outcome of each administration. A resident centred care plan was not in place for one resident, this was highlighted to the manager for correction and assurances were provided that this would be implemented immediately.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required. Care plans were in place and reviewed regularly.

The management of warfarin was reviewed. Warfarin is a high risk medicine which requires regular blood testing. The dose of warfarin prescribed depends on the blood test result. A resident specific care plan was in place. Blood tests had been carried out at the identified times and warfarin had been administered as prescribed. Two staff were involved where transcribing of warfarin doses occurred. Some obsolete records had not been archived, this could lead to an incorrect dose being administered. This was highlighted to the manager for immediate corrective action.

The management of red list medicines was reviewed. Red list medicines are medicines which are prescribed by a specialist and dispensed directly from the hospital pharmacy. While staff were aware of the ordering, delivery and monitoring arrangements for this medicine a care plan was not in place. This was discussed with the senior carer for correction.

### 3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the resident's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

Records reviewed showed that medicines were available for administration when residents required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. Some gaps in the temperature records were highlighted to the manager for ongoing monitoring.

Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and disposal of medicines.

### 3.3.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to residents to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Most of the records were found to have been accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing monitoring. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Occasionally, residents may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the resident's care plan. Care plans contained sufficient detail to describe how the resident's medicines were administered and appropriate arrangements were in place.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that action plans had been implemented and addressed. Staff were reminded of the importance of recording the date of opening on medicines to facilitate audit and disposal at expiry. The manager agreed to monitor this through the home's medicine audit.

### 3.3.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

Records reviewed indicated that staff had not received written confirmation of one recently admitted resident's current prescribed medicines from their GP. Medicines were being administered in accordance with information provided by the previous care home. There is a potential that recent medication changes may not have been implemented. An area for improvement was identified.

### 3.3.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the staff on duty and the manager for on-going monitoring.

### 3.3.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that they staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

## 4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Standards.

| | Regulations | Standards |
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| **Total number of Areas for Improvement** | 7* | 6* |

* the total number of areas for improvement includes eleven which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Leslie Stephens, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

| Quality Improvement Plan | |
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| **Action required to ensure compliance with The Residential Home Regulations (Northern Ireland) 2005** | |
| **Area for improvement 1**<br><br>**Ref:** Regulation 21 (1) (b) Schedule 2 (5)<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>22 May 2025 | The registered person shall ensure that the NISCC audit is kept up to date, includes all relevant staff and accurately reflects their registration status. |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |
| **Area for improvement 2**<br><br>**Ref:** Regulation 19 (1) (b)<br><br>**Stated:** First Time<br><br>**To be completed by:**<br>22 May 2025 | The registered person shall ensure that confidential information relating to residents is safely secured. |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |
| **Area for improvement 3**<br><br>**Ref:** Regulation 27 (2)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>23 July 2025 | The registered person shall ensure that there is a time bound refurbishment plan outlining the planned refurbishments to the home; including those areas discussed as part of the inspection. This should include projected timeframes for the works to take place. |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |
| **Area for improvement 4**<br><br>**Ref:** Regulation 27 (2) (d)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>22 May 2025 | The registered person shall ensure that all parts of the home are kept clean. |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |

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| **Area for improvement 5**<br><br>**Ref:** Regulation 14 (2) (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>22 May 2025 | The registered person shall ensure that residents do not have access to substances hazardous to their health such as the domestic cleaning trolley and denture cleaning tablets.<br><br>**Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |
| **Area for improvement 6**<br><br>**Ref:** Regulation 27 (4) (a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>22 May 2025 | The registered person shall ensure that fire safety precautions are in place to protect residents, staff and visitors. This area for improvement is in relation to the propping open of fire doors.<br><br>**Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |
| **Area for improvement 7**<br><br>**Ref:** Regulation 10 (1)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>22 May 2025 | The registered person shall ensure that a robust governance system is implemented and maintained to promote and assure the quality of services in the home.<br><br>**Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |
| **Action required to ensure compliance with the Care Standards for Residential Homes, December 2022** | |
| **Area for improvement 1**<br><br>**Ref:** Standard 31<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 June 2025 | The registered person shall ensure personal medication records are accurate and up to date.<br><br>Ref: 3.3.1<br><br>**Response by registered person detailing the actions taken:**<br>Supervision has taken place to remind staff that the Personal Medication Record needs to be accurate and kept up to date at all times. The compliance will be monitored during the monthly medication audit and spot checked as part of the Regulation 29 visit by the Operations Manager. |

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| **Area for improvement 2**<br><br>**Ref:** Standard 30<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 June 2025 | The registered person shall review the procedures for managing medicines at the time of admission and ensure written confirmation of the resident's current prescribed medicines is obtained from the prescriber.<br><br>Ref: 3.3.1 & 3.3.4 |
| | **Response by registered person detailing the actions taken:**<br>Staff supervision has taken place in relation to the correct process for verifying medication on admission to the Home, whether this is through liaising with the General Practitioner or directly from the Hospital, dependent on their care pathway. This will be checked as part of the admission governance audit process and through the month medication audit. The Operations Manager will spot check this during the course of the Regulation 29 visit. |
| **Area for improvement 3**<br><br>**Ref:** Standard 6.6<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>30 June 2025 | The registered person shall ensure that there is evidence of resident involvement in the care planning process where appropriate. |
| | **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |
| **Area for improvement 4**<br><br>**Ref:** Standard 24.2<br><br>**Stated:** First time<br><br>**To be completed by:**<br>30 June 2025 | The registered person shall ensure that all staff have recorded individual, formal supervision no less than every six months. |
| | **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |
| **Area for improvement 5**<br><br>**Ref:** Standard 8<br><br>**Stated:** First time<br><br>**To be completed by:**<br>22 May 2025 | The registered person shall ensure that all records are kept up to date, legible and accurate. This area for improvement relates to post fall observation records. |
| | **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |

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| **Area for improvement 6**<br><br>**Ref:** Standard 8<br><br>**Stated:** First time<br><br>**To be completed by:**<br>22 May 2025 | The registered person shall ensure that all records are kept up to date, legible and accurate. This area for improvement relates to Dysphagia Diet Standardisation Initiative (IDDSI) levels. |
| | **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 2.0 |

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